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**Vasectomy Self-Referral Form**

**REMINDER:** If this form is not completed correctly, your referral will **not** be accepted.

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| **Patient Information** |
| **Full Name** | Click or tap here to enter text. |
| **Date of Birth** | Click or tap here to enter text. |
| **Address** | Click or tap here to enter text. |
| **Postcode** | Click or tap here to enter text. |
| **Mobile Number** | Click or tap here to enter text. |
| **Email Address** | Click or tap here to enter text. |
| **Occupation** | Click or tap here to enter text. |
| **GP Practice** | Click or tap here to enter text. |

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| **Pre-Referral Questionnaire** |
| **How long have you been considering a Vasectomy?** | Click or tap here to enter text. |
| **Do you have any health conditions we should know about?** | Click or tap here to enter text. |
| **Do you take any medications? Particularly blood thinners or immunosuppressants?** | Click or tap here to enter text. |
| **Do you have any allergies? Particularly to anaesthetic?** | Click or tap here to enter text. |
| **Have you ever had any surgery on your scrotum before?** | Click or tap here to enter text. |
| **Do you suffer any pain, lumps or problems with your scrotum?** | Click or tap here to enter text. |
| **If you have a partner, have you discussed this decision with them and how old are they?** | Click or tap here to enter text. |
| **Do you have children already? If so, how many and how old are they?** | Click or tap here to enter text. |
| **What are you currently using to prevent pregnancy?** | Click or tap here to enter text. |

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| **Location Preference** |
| **Do you have a preference on the location of your procedure?** | Choose an item. |

Please email your completed form to **syicb-doncaster.doncastervasectomy@nhs.net** where we aim to respond to your referral within 14 working days and will contact you via the information you have provided above.

Sincerely,

Don Valley Healthcare & The Scott Practice